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RR RUEHDU RUEHJO RUEHMR
DE RUEHSA #1415/01 0971242
ZNR UUUUU ZZH
R 071242Z APR 06
FM AMEMBASSY PRETORIA
TO RUEHC/SECSTATE WASHDC 2676
INFO RUCNSAD/SOUTHERN AFRICAN DEVELOPMENT COMMUNITY
RUCPDC/DEPT OF COMMERCE WASHDC
RUEATRS/DEPT OF TREASURY WASHDC
RUEAUSA/DEPT OF HHS WASHDC
RUEHPH/CDC ATLANTA GA 1116

UNCLAS SECTION 01 OF 04 PRETORIA 001415

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CDC FOR SBLOUNT AND DBIRX

E.O. 12958: N/A
TAGS: ECON KHIV SOCI TBIO EAID SF
SUBJECT: SOUTH AFRICA PUBLIC HEALTH April 7 2006 ISSUE

Summary

¶1. Summary. Every two weeks, Embassy Pretoria publishes a public health newsletter highlighting South African health issues based on press reports and studies of South African researchers. Comments and analysis do not necessarily reflect the opinion of the U.S. Government. Topics of this week's newsletter cover: Focus on South Africa and TB; SA's TB Cure Rate Still Poor; TB Crisis Plan Targets Four Districts; Western Cape's High Cure Rate; Zambia and South Africa Tests Effectiveness of Community Public Health Interventions; HIV Education in Prisons; Finland and South Africa Collaboration in Aids Research; South Africa's Avian Flu Contingency Plan; South African Development of AIDS Vaccines; SA Prevents TAC from Attending UN AIDS Session; and TAC Plans to Attend UN Session. End Summary.

Focus on South Africa and TB

¶2. March 24 was International TB Day and the following articles present South African statistics and research on the disease. World Health Organization data shows South Africa having the third highest overall TB prevalence in the continent after Nigeria and Ethiopia and the fifth highest number of new TB cases in 2004 globally just after India, China, Indonesia and Nigeria.

SA's TB Cure Rate Still Poor

¶3. Little more than half of all tuberculosis patients are cured in South Africa, multi-drug resistant TB is increasing, and yet new drug regimens may provide optimism on increasing South Africa's TB cure rate of 54%. In 2003, approximately 185,000 new TB cases were diagnosed in South Africa, rising by 94,000 cases in a single year, with 279,000 new TB cases in ¶2004. South Africa's cure rate falls short of the World Health Organization's goal of 85%. South Africa has the eighth highest TB burden in the world and deaths from untreated TB are high. Dr Lindiwe Mvusi, the Health Department's National TB Manager, believes that the increase in cases shows that people are reporting to clinics at an earlier stage of their TB infection. Multi-drug resistant (MDR) TB is an increasing problem, which does not respond to the usual six-month regimen of ordinary TB drugs and needs more expensive drugs that are

taken for about 18 months. Usually only half of MDR TB patients are cured. Mvusi said that 1.6% of new TB cases are MDR TB while 6.7% of patients who are being retreated for TB are diagnosed as having MDR-TB. HIV is also adding to the TB burden, with a high proportion of people with TB also being co-infected with HIV. Professor Valerie Mizrahi, co-Director of the Center for Excellence for Bio-medical TB Research at the National Health Laboratory Service points to recent improvements in TB drug development as reasons for hope. She stated that there have been no new TB drugs for 40 years and suddenly, over the last five to 10 years, new research in the science underlying TB disease and the bacteria that causes TB, there has been renewed interest in the field. South Africa is participating in Phase 2 trials for new drugs and combinations to treat TB, with major studies in Cape Town and Durban. The Global Alliance for TB Drug Development thinks new TB drugs will be available by 2010. Source: Health-e News, March 24.

TB Crisis Plan Targets Four Districts

¶4. South Africa's TB crisis plan will focus initially on four health districts with both poor TB cure rates and many TB patients, namely eThekwini metro (Durban), Johannesburg, the Nelson Mandela metro (Port Elizabeth) and Amatola district (East London). The official start of the plan began at King George V Hospital in eThekwini, the worst performing metropolitan area in the country with over 24,000 new TB patients in 2004, and a cure rate of less than one in three. Health Minister Tshabalala-Msimang cited critical elements to the success of the plan as adequate human and financial resources, access to laboratory services, better TB reporting, recording and referral of patients and a highly visible social mobilization and media campaign. The Minister played down the

link between TB and HIV, despite consensus among medical experts that HIV is driving the TB epidemic. While the crisis plan includes joint HIV and TB measures, Tshabalala-Msimang said that making the link between the two epidemics could mean that patients were double stigmatized. Multi-drug resistant TB is a serious problem. While TB cost between R400 ($67, using 6 rands per dollar) and R600 ($100) for a six month treatment, it cost R24,000 ($400) to treat someone with MDR TB. Doctors from King George Hospital, which has one of the biggest MDR TB case loads in the country, said there was little information about how the MDR TB drugs interacted with antiretroviral drugs. Source: Health e-News, March 24.

Western Cape's High Cure Rate

¶5. Two Western Cape health districts are recording in excess of 80% TB cure rates. Dr. Keith Cloete, acting head of the provincial health department, attributes this to patient monitoring and committed staff. The Eden district which includes Knysna, George, Plettenberg Bay, Oudtshoorn, Riversdale and Beaufort West had 5,366 TB patients in 2004 and recorded a cure rate of 81.8%. The Overberg district which includes Caledon cured 84.5% of its 2,437 patients in 2004. The Cape Town metropolitan area had 25,824 TB cases in 2004, with a cure rate of 64.8%. Numbers in Cape Town have increased significantly at clinics in areas such as Khayelitsha and Nyanga where the TB epidemic is being fuelled by the HIV epidemic. The Western Cape Province has increased funding to the TB program which will be used to employ more staff, channel more money to the non-governmental sector for treatment supporters and increase capacity at the laboratories. Five sub-districts will receive more funding in 2006: the Breede Valley (Worcester), Drakenstein (Paarl), Eastern (Helderberg and Oostenberg), Khayelitsha and Klipfontein (Old Nyanga and Athlone). In 2005 Klipfontein had 3,769 TB cases and Khayelitsha 5,640 with cure rates of 67.9% and 51.7%, respectively. The Western Cape's TB cases have increased from 27,509 cases in 1997 to 47,603 in 2005. Source: SAPA, March 23; Health E-News, March 24.

Zambia and South Africa Test Effectiveness of Community Public Health Interventions

¶6. Zamstar, the Zambia South Africa Tuberculosis and AIDS Reduction Study, is trying to improve TB treatment by focusing on public health interventions in 8 communities in the Western Cape and 16 in Zambia. Clinic-based HIV and TB interventions are a critical part of the study, with both TB and HIV services working closely together. All TB patients will be tested for HIV and all patients going for Voluntary Counseling and Testing at the HIV Clinic will be referred for TB testing. At community level, awareness will also be raised using simple messages. In schools, Zamstar workers will be raising TB awareness from grade one to 12, moving from school to school and setting up sputum (mucus) collection points. Zamstar's aim is to ensure that every person in the target communities will be able to give a sputum sample at least three times a year to a place which is within a 30 minute walk. Community health workers will also be doing household interventions where TB has been diagnosed. These homes will be viewed as being at risk of HIV and TB. In 2009, prevalence studies will be done where 5,000 adults will be tested for TB, key to establish how many people remained undiagnosed despite the interventions.

¶7. In South Africa, Nyanga, Phillipi, Khayelitsha Site C, Harare, Wallacedene, Delft-South, Kayamandi and Mbekweni/Phola Park will participate. A quality assurance team will travel between South Africa and Zambia to monitor among others the quality of the interventions as well as the laboratory services. The South African study is run in close collaboration with the Provincial TB Program and TB services in the Cape Town metro. The community interventions, which will last three years, start in April. It has already taken 18 months to get support from the community and establish a community advisory board. Source: Health e-News, March 24.

HIV Education in Prisons

¶8. A study by the South African Medical Research Council points to success in education prevention interventions aimed at sexually transmitted diseases for male South African prisoners. Dr. Sibusiso Sifunda studied four prisons, two in KwaZulu-Natal and two in Mpumalanga, and found that HIV education programs with participation by former inmates led to safer sex along with intentions to reduce risky behavior in sexual encounters. According to Sifunda, appropriate education would provide the prisoners critical life skills and would help prevent additional infections of sexually-transmitted diseases. Low prisoner education served as a major barrier to traditional health education techniques, such as government-issued leaflets. The study reported that most inmates will have sex within the first few days of being released, risking increased transmission. Source: Cape Argus, March 30.

Finland and South Africa Collaboration in AIDS Research

¶9. The Perinatal HIV Research Unit (PHRU) and FIT Biotech, a Finnish biotechnology company, will collaborate to test the safety of a vaccine that may control the progression of HIV to AIDS. This is the first vaccine aimed at already infected individuals and the clinical trial will determine the dosage as well as the best way to administer the vaccine. According to the clinical trial's principal investigator, Dr. Eftyhia Vardas, clinical virologist at PHRU, the vaccine would keep the viral load of infected individuals down, while increasing the person's CD4 cells. According to the SA AIDS Vaccine Initiative, phase-one safety studies on the vaccine were completed in Finland and showed an excellent safety profile. South African enrollment began at the end of March with suitable candidates being HIV-positive, between the ages of 18

and 40, with a CD4 count greater than 400 and not on anti-retroviral treatment. The target enrollment is 54 patients in South Africa and another 6 in Finland. The phase 2 study would last one year. Source: The Star, March 31.

South Africa's Avian Flu Contingency Plan

¶10. South Africa has started strict import controls and an extensive surveillance program to prevent an outbreak of the H5N1 avian flu. South Africa has yet to record a positive case of avian flu among domestic or wild birds within its borders and authorities want to ensure that this continues. The contingency plans include: (1) banning the import of live birds from any countries where the virus has been confirmed; (2) quarantining and testing any birds imported from virus-free countries; and (3) prohibiting the import of live pigs from affected countries. Surveillance of wild birds, domesticated ostriches, commercial and non-commercial chickens will be done every 6 months in different areas. In the event of an outbreak, immediate quarantine, culling and vaccination of staff and labor in contact with infected birds will begin. A Disease Control Center will coordinate the necessary actions to handle the disease outbreak. The national Department of Health has sent its preparedness plan to Cabinet for endorsement and once endorsed, the plan will be public. Source: Pretoria News, March 28.

South African Development of AIDS Vaccines

¶11. Dr. Glenda Gray, co-Director of the Perinatal HIV Research Unit expects that a South African AIDS vaccine might be available within four to five years. Two locally-developed vaccines had already been tested for effectiveness in mice and baboons and showed promising results. Gray hoped that human trials would start in Africa and America in January or February ¶2007. South African research is concentrating on the sub-type C HIV epidemic, accounting for 50% of global infections. Research in Europe concentrated on sub-type B HIV. Gray worries that so much research is concentrated on the vaccine itself, without considering manufacturing or dispensation problems that might block the most effective HIV/AIDS treatment. Other South African medical analysts were not as optimistic about the five year vaccine availability. Michelle Galloway of the Medical Research Council agreed with Gray's assessment of the quality of South African vaccine research, yet sounded a cautionary note about the development speed,

noting that the first and second phase typically takes two to three years each while the third phase takes between three and five years. She also stated that it took 20 to 30 years to develop vaccines for other viruses, and HIV is more complex. Source: City Press, April 2.

SA Prevents TAC from Attending UN AIDS Session

¶12. Due to objections from the national Department of Health, the Treatment Action Campaign (TAC) and its affiliate, the AIDS Law Project will not be able to attend the UN General Assembly's special session on AIDS, scheduled for May 31 to June 2. According to Thami Mseleku, the Director-General of Health, the Department objected to TAC's presence because they used previous global forums to vilify the government. He said that the government would rather resolve its differences with the TAC within the country. Mseleku said that this decision had been made by the Health Department without consulting the President's office. Source: Sunday Independent, April 2; The Mercury, April 3.

TAC Plans to Attend UN Session

¶13. The Treatment Action Campaign (TAC) plans to attend the

late May UN session on AIDS by being included as representatives of other non-governmental organizations if they are not included in the South African government's official country delegation. Mark Heywood, a member of the TAC executive committee has stated that a number of already accredited organizations have offered TAC places in their delegations. The TAC and the Aids Law Project are two of six organizations worldwide denied accreditation for participation. Source: Pretoria News, April 6.

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